

Household Number:  
PI Recipient Number:

CAT1 Budget Group Number:  
Spouse's Recipient Number:

CAT2 Budget Group Number:  
Worker ID:

## South Carolina Department of Health and Human Services Addendum for Medicare Savings Programs

This addendum is developed specifically for the following Medicare Savings Programs (MSP):  
Aged Blind Disabled/Qualified Medicare Beneficiaries (ABD/QMB); Specified Low Income Beneficiaries (SLMB); and Qualifying Individuals (QI)

You recently applied for the Low-Income Subsidy with the Social Security Administration (SSA). When you applied, you also asked for SSA to send your application to the South Carolina Department of Health and Human Services to see if you may be eligible for a Medicare Savings Program (MSP). If approved for an MSP, you will get help to pay your Medicare Part B premium and you may get help to pay your Medicare co-insurance and deductible. We have your application from SSA and need some other information to see if we can help. Please answer all of the questions below and return this form by \_\_\_\_\_. We may also ask for proof of income and resources. If you have any questions about this form or the proof we are asking for, please call 1-888-549-0820 (TTY 888-842-3620). The address to return the form and any information is:

If we do not hear from you by \_\_\_\_\_, we will think you do not want us to see if you are eligible, and you will get a letter to let you know that we have denied your application.

### 1. Please check the information shown below about you. Make any corrections and fill in any missing information.

First Name	Middle Name	Last Name	Suffix	
Social Security Number XXX – XX -	Health Insurance Claim Number	Date of Birth	Gender	County
Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Multi Race <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/Unknown * You must provide proof to be considered a member of a Federally Recognized Native American tribe				
Mailing Address		Street Address		
City: ZIP:		STATE: Phone Number:		

### 2. Please check the information shown below about your spouse. Make any corrections as needed and fill in any missing information.

First Name	Middle Name	Last Name	Suffix	
Social Security Number XXX – XX -	Health Insurance Claim Number	Date of Birth	Gender	
Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Multi Race <input type="checkbox"/> Federally Recognized Native American* <input type="checkbox"/> Other Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/Unknown				

### 3. Please tell us about any natural, adopted, or step children under age 22 that live with you.

Name	Relationship	Birthday (Mo/Day/Yr)	Sex	Race	SC Resident	Social Security Number (Optional)	Is this child a full- time student
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you or anyone in your home receive, or have applied for, any other income? ☐ Yes ☐ No

If Yes, check all boxes that apply and complete the table below

<input type="checkbox"/> Social Security benefits (RSDI) <input type="checkbox"/> Pension/retirement benefits <input type="checkbox"/> Wages/Earned Income/Self-Employment <input type="checkbox"/> Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement) <input type="checkbox"/> Other (Please be specific): _____	<input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Veterans benefits <input type="checkbox"/> Rental Income	<input type="checkbox"/> Disability benefits <input type="checkbox"/> Unemployment benefits
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Person receiving/expecting money	Income source/type	How often received	Amount received	Comments

**Except for your Social Security, please send proof of all the income you get each month.**

5. Are you or your spouse a Veteran? ☐ Yes ☐ No

6. Do you or your spouse have any of the following? ☐ Yes ☐ No

If Yes, check all boxes that apply and complete the table below.

**When we start working on your application, we may ask you to send in proof of the resources you tell us about.**

<input type="checkbox"/> Bank Checking Account <input type="checkbox"/> Trust Fund or Trust Account <input type="checkbox"/> Annuity (If Yes, provide a copy) <input type="checkbox"/> Farm Machinery or Business Equipment <input type="checkbox"/> Life Insurance <input type="checkbox"/> Money Set Aside for Burial <input type="checkbox"/> Other (Please be specific): _____	<input type="checkbox"/> Bank Savings Account <input type="checkbox"/> Safe Deposit Box (Include a list of the contents) <input type="checkbox"/> Stocks, Bonds, or Mutual Funds <input type="checkbox"/> 401K, IRA or other Retirement Account <input type="checkbox"/> Pre Need Burial Contract <input type="checkbox"/> Homestead Property	<input type="checkbox"/> Certificate of Deposit <input type="checkbox"/> Car, Truck, Van <input type="checkbox"/> Motorcycle, Boat, Camper <input type="checkbox"/> Cash on Hand <input type="checkbox"/> Cemetery Burial Space <input type="checkbox"/> Non-Homestead Property
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Owned By	Type of Account - or - Type of Asset	Account Number - or - Asset Description	Current Value or Balance	Name and Address of Institution

7. Do you or your spouse have any other health insurance? (If Yes, send a copy of your card(s)) ☐ Yes ☐ No

8. Did you or your spouse receive medical services in the previous three (3) months? ☐ Yes ☐ No

Signature of applicant:	Date:
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9. Do you want to name someone as your Authorized Representative? This is someone we will contact if we have any questions about your application. We will also send letters and notices to this person. ☐ Yes ☐ No

Name of Authorized Representative: (Please Print)	Signature of Authorized Representative:	Relationship:
Address of Authorized Representative:	Telephone:	Date:

## Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: [civilrights@scdhhs.gov](mailto:civilrights@scdhhs.gov).

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Language Services

**If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).**

**si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).**

إذا كانت لغتك الأساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجاناً. اتصل على الرقم:  
**(1-888-842-3620) (رقم هاتف الصم والبكم 1-888-842-3620)**

**Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).**

**Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).**

**Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).**

**Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)**

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

**Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.**

**धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह । 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर ।**

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

**Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.**

**Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).**

နမူနာကတိ ကညီ ကျိအယိ, နမူနာ ကျိအတိမၤစၢလၢ တလၢ်ဘျၢ်လၢ်စ့ၢ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး  
888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው፡ 1-888-842-3620)፡፡

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ငဲ့အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။